Note: The example is simplified for presentation. Original investment was assumed to be made at one time. There are no loan costs or start up costs factored in the original purchase or subsequent purchase.

VI. Year End Conformance:

Facilities with fiscal years beginning January 1, 1997 through December 1, 1997 will not have a Year End Conformance applied.

For subsequent fiscal periods, year end conformance will be reviewed for each facility. Approved ancillary rates for the fiscal year ended 24 months before the beginning of the rate year will be compared to the actual ancillary cost per patient day for that period. An adjustment to the prospective rate will be calculated as 90 percent of the difference between the approved ancillary rate and the actual ancillary cost per patient day. If actual total facility costs per day are less than two percent above or below the approved total rate (without year end conformance in the base year rate, if any) no adjustment will be made. A positive adjustment will be limited to the amount that actual total facility costs exceeded the overall approved total rate (without year end conformance in the base year rate, if any) in the base year, and a negative adjustment will be limited to the amount that the approved total rate (without year end conformance in the base year rate, if any) in the base year exceeded the actual total facility costs in the base year.

The Department will, in its discretion, waive all or part of the year end conformance if the facility provides justification that manifest injustice will result if year-end conformance is strictly applied, based upon consideration of the following factors:

- whether the facility has taken effective measures to control costs in response to the situation upon which the waiver request is based.

- whether the waiver request contradict a prior action of the Department as to an element of the facility's rate.

- whether the waiver would result in payment for only allowable cost of services authorized by the division of medical assistance under state or federal laws.

- whether the situation upon which the waiver request is based results from the provision of direct patient care or from prudent management actions improving the financial viability of the facility to provide patient care.

VII. Adjustment to Rates:

Rates for facilities are set by the Department with the advice of five Governor appointed Commissioners. The Commissioners represent the state of Alaska, the providers, a physician, a certified public accountant and a consumer. Facilities have the opportunity to provide additional information on significant changes that would impact the rates.

The Department, on its own or at the request of an applicant, in its discretion, will reconsider its actions within 30 days. There is nothing to preclude a facility from petitioning the Department at any time during its fiscal year for additional consideration.

Reconsiderations are warranted only in those cases where the proper application of the methods and standards described in Attachment 4.19-D is in question or is being challenged.

VIII. Provider Appeals:

If a party feels aggrieved as a result of the Department's rate setting decisions, the party may appeal and request reconsideration or an administrative hearing.

Administrative hearings are conducted by Governor appointed Hearing Officers. An administrative appeal must be filed within 30 days of the mailing of the decision of the Department.

The Hearing Officer would hear a case in accordance with administrative law in the state of Alaska. The Hearing Officer would prepare draft findings, conclusions and order for the Commissioner of the Department's review. The Commissioner of the Department would review the findings of the Hearing Officer and may accept, reject, or modify the Hearing Officer's recommendations. If the party still feels aggrieved at this point, judicial review is available to contest actions of the Department and the rate set.

IX. Audit Function:

The Department has statutory authority to audit data relating to Medicaid prospective payment rates. Audit findings that would affect prospective payment rates are adopted by the Department and incorporated into future prospective rate calculations.

X. Exceptional Relief to Rate Setting:

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the Deputy Commissioner of the Department for exceptional relief from the rate setting methodology.

This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;

2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;

3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;

4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. an analysis of community needs for the service on which the exception request is based;

7. a detailed analysis of the options of the facility if the exception is denied;

8. a plan for future action to respond to the problem; and

9. any other information requested by the Deputy Commissioner to evaluate the request.

The Deputy Commissioner may request recommendations from the Commission on a facility's application for exceptional relief. The Deputy Commissioner may increase the rate, by all or part of the facility's request if the Deputy Commissioner finds by clear and convincing evidence that the rate established under Section IV. and Section VI. of Attachment 4.19-D does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the Deputy Commissioner may consider at least:

1. **the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;**

2. **the assessment of continued need for this facility's services in the community;**

3. **whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;**

4. **the recommendations, if any, from the Commission;**

5. **the availability of other resources available to the facility to respond to the crisis;**

6. **whether the relief should have been obtained under the existing rate methodology;**

7. **other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.**

The Deputy Commissioner may impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. **the facility sharing the cost of the rate exception granted;**

2. **the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;**

3. **the facility providing documentation as specified of the continued need for the exception; or**

4. a maximum amount of exceptional relief to be granted to the facility under this section.

If the Deputy Commissioner finds by clear and convincing evidence that the rate established under the methodology does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest, the Deputy Commissioner may, in his or her sole discretion increase the rate.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the Deputy Commissioner concerning exceptional relief may request an administrative hearing to the Commissioner of the Department.

ALASKA STATUTES

Binder 9

TITLE 46 TO TITLE 47

TABLES

1994 Cumulative Supplement

OCTOBER 1994

Effective Date of Statutes
See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 4105. For complete list of scope of annotations, see scope page in front of this supplement to first binder. For detailed information on the use of the Alaska Statutes, see User's Guide published following the scope page.

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TN #: 95-06 DATE APPROVED: July 2, 1996
SUPERSEDES TN#: 95-18 DATE EFFECTIVE: October 1, 1995

Chapter 05. Administration of Welfare, Social Services and Institutions.

Sec. 47.05.017. Home care providers. (a) State money may not be used for a home care provider unless records under AS 12.62.035 a) are requested for the provider within 10 business days after the provider is hired to provide the care and are reviewed within five business days after they are received. The department shall require the grantee or contractor to do the records request and review required under this subsection for a home care provider employed by a person who has a grant or contract from the department to provide home care services.

(b) The department shall adopt regulations identifying actions that it will take, in addition to those otherwise required under AS 47.17 and AS 47.24, when a report of harm is made under AS 47.17 or AS 47.24 that might relate to harm caused by actions or inactions of a public home care provider. The regulations must

(1) address circumstances under which the department will, or will require a contractor or grantee to, reassign, suspend, or terminate a person alleged to have perpetrated harm; and

(2) include appropriate procedural safeguards to protect the due process rights of public home care providers who may be reassigned, suspended, or terminated under the circumstances described in (1) of this subsection.

(c) In this section, "public home care provider" means a person who is paid by the state, or by an entity that has contracted with the state or received a grant from state funds, to provide homemaker services, chore services, personal care services, home health care services, or similar services in or around a client's private residence or to provide respite care in either the client's residence or the caregiver's residence or facility. (§ 2 ch 45 SLA 1994)

Cross references. — For date by which regulations must be adopted and required to report to the legislature, see § 9, ch. 45, SLA 1994 in the Temporary and Special Acts.

Effective dates. — Section 10, ch. 45, SLA 1994 makes this section effective May 24, 1994, in accordance with AS 01.10.070(c).

Sec. 47.05.030. Misuse of public assistance lists and records.

NOTES TO DECISIONS

Quoted in Hertz v. Hertz, 847 P.2d 71 (Alaska 1993).

Sec. 47.05.060. Purpose and policy relating to children.

NOTES TO DECISIONS

Protection of children is the paramount purpose.

Child in Need of Aid proceedings are designed to protect children from injury or mistreatment and to help safeguard their physical, mental and emotional well-being. In re A.S.W., 834 P.2d 801 (Alaska 1992).

Quoted in L.O. v. State, 816 P.2d 1352 (Alaska Ct. App. 1991).

Chapter 07. Medical Assistance for Needy Persons.

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children) or 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income);

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220;

(11) **[See delayed amendment note]** persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b)(4) of this section, a person is not eligible for Medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act).

(f) A person may not be denied eligibility for medical assistance under this chapter on the basis of a diversion of income, whether by assignment or after receipt of the income, into a Medicaid-qualifying trust that, according to a determination made by the department,

(1) has provisions that require that the state will receive all of the trust assets remaining at the death of the individual, subject to a maximum amount that equals the total medical assistance paid on behalf of the individual; and

(2) otherwise meets the requirements of 42 U.S.C. 1396p(d)(4).

(g) A person's eligibility for medical assistance under this chapter may not be denied or delayed on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship on the person as determined on the basis of criteria in applicable federal regulations. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988; am § 38 ch 168 SLA 1990; am § 1 ch 76 SLA 1993; am § 17 ch 102 SLA 1994)

Delayed amendment of subsection (b). — Under Section 4, ch. 76, SLA 1993, paragraph (b)(11) takes effect on the 180th day after the effective date of Medicaid plan amendments approved by the federal government under which the state would implement a waiver for home and community-based services under 42 U.S.C. 1396n for persons who are Medicaid eligible and who would otherwise require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded in the absence of home and community-based services.

Cross references. — For legislative purposes in enacting (f) of this section, see

§ 1, ch. 102, SLA 1994 in the Temporary and Special Acts.

Effect of amendments. — The 1993 amendment added paragraphs (b)(10) and (b)(11).

The 1994 amendment, effective September 7, 1994, added subsections (f) and (g).

Sec. 47.07.025. Assignment of medical support rights. (a) An applicant for or recipient of assistance under this chapter is considered to have assigned to the state, through the department and the child support enforcement agency, all rights to accrued and continuing medical support that the applicant and other persons for whom assistance is sought may have from all sources. The assignment takes effect upon a determination that the applicant is eligible for assistance under this chapter. Except with respect to the amount of any unpaid medical support obligation accrued under the assignment, the assignment under this section terminates when the applicant ceases to receive assistance under this chapter.

(b) Through the child support enforcement agency or on its own behalf, the department may garnish the wages, salary, or other employment income of a person who

(1) is required by a medical support order under AS 25.27.063 to provide coverage of the costs of medical care to a child who is eligible for medical assistance under this chapter;

(2) has received payment from a third party for the costs of the services; and

(3) has not used the payments to reimburse, as appropriate, the other parent or custodian of the child, the provider of the services, or the department.

(c) Garnishment under (b) of this section is limited to the amount necessary to reimburse the department for expenditures for the child under this chapter. Claims for current support or support arrearages take priority over claims under this section. (§ 18 ch 102 SLA 1994)

Cross references. — For legislative purposes in enacting this section see § 1, ch. 102, SLA 1994 in the Temporary and Special Acts.

Effective dates. — Section 18, ch. 102, SLA 1994, which enacted this section, took effect on September 7, 1994.

Sec. 47.07.030. Medical services to be provided. (a) The department shall offer all mandatory services required under 42 U.S.C. 1396 — 1396p (Title XIX of the Social Security Act).

(b) In addition to the mandatory services specified in (a) of this section, the department may offer only the following optional services: case management and nutrition services for pregnant women; personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; advanced nurse practitioner services; clinic services; rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults; targeted case management services for

substance abusers, chronically mentally ill adults, and severely emotionally disturbed persons under the age of 21; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; psychologists' services; clinical social workers' services; midwife services; prescribed drugs; physical therapy; occupational therapy; chiropractic services; low-dose mammography screening, as defined in AS 21.42.375(e); hospice care; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care.

(c) Notwithstanding (b) of this section, the department may offer a service for which the department has received a waiver from the federal government if the department was authorized, directed, or requested to apply for the waiver by law or by a concurrent or joint resolution of the legislature. The department shall annually submit to the legislature its recommendations about where a service offered under this subsection should be placed on the priority list in AS 47.07.035.

(d) The department may use a case management system under which certain eligible individuals are required to seek approval from the case manager before receiving some services under this chapter and under which certain services may be denied eligibility under this chapter if the case manager does not approve provision of the service. A case manager may approve coverage of an optional service listed in AS 47.07.035, notwithstanding that coverage of that service may have been eliminated under AS 47.07.035. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982; am § 1 ch 20 SLA 1986; am § 4 ch 105 SLA 1986; am § 2 ch 119 SLA 1988; am § 3 ch 45 SLA 1989; am § 3 ch 69 SLA 1991; am § 1 ch 70 SLA 1991; am § 1 ch 38 SLA 1992; am § 1 ch 110 SLA 1992; am § 2 ch 51 SLA 1993; am § 1 ch 75 SLA 1993; am § 2 ch 76 SLA 1993; am § 19 ch 102 SLA 1994)

Effect of amendments. — The first 1991 amendment, effective September 19, 1991, inserted "low-dose mammography screening, as defined in AS 21.42.375(e)" near the middle of subsection (b).

The second 1991 amendment, effective September 19, 1991, inserted "psychologists' services; clinical social workers' services" near the middle of subsection (b).

The first 1992 amendment, effective July 1, 1992, in subsection (b), inserted "rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults; targeted case management services for substance abusers, chronically mentally ill adults, and severely emotionally disturbed persons under the age of 21;".

The second 1992 amendment, effective September 20, 1992, inserted "advanced nurse practitioner services;" in subsection (b).

The first 1993 amendment, effective July 1, 1993, inserted "midwife services" near the middle of subsection (b).

The second 1993 amendment, effective

January 1, 1994, inserted "hospice care" near the end of subsection (b).

The third 1993 amendment, effective June 26, 1993, added subsection (c).

The 1994 amendment, effective September 7, 1994, added subsection (d).

Sec. 47.07.035. Priority of medical assistance. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

(1) midwife services;
(2) clinical social workers' services;
(3) psychologists' services;
(4) chiropractic services;
(5) advanced nurse practitioner services;
(6) adult dental services;
(7) emergency hospital services;
(8) treatment of speech, hearing, and language disorders;
(9) optometrists' services and eyeglasses;
(10) occupational therapy;
(11) mammography screening;
(12) prosthetic devices;
(13) medical supplies and equipment;
(14) targeted case management services;
(15) rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults;
(16) clinic services;
(17) physical therapy;
(18) personal care services in a recipient's home;
(19) prescribed drugs;
(20) hospice care;
(21) long-term care noninstitutional services;
(22) inpatient psychiatric facility services;
(23) intermediate care facility services for the mentally retarded;
(24) intermediate care facility services;
(25) [See delayed amendment note] individuals described in AS 47.07.020(b)(11);
(26) individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;
(27) skilled nursing facility services for persons under age 21;
(28) aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or

intermediate care facility, to receive an optional state supplementary payment;
(29) individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;
(30) individuals under age 21 under supervision of the department for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions.
(31) individuals under age 21 who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986; am § 3 ch 119 SLA 1988; am § 4 ch 45 SLA 1989; am § 38 ch 168 SLA 1990; am § 4 ch 69 SLA 1991; am § 2 ch 70 SLA 1991; am § 2 ch 38 SLA 1992; am § 2 ch 110 SLA 1992; am § 3 ch 51 SLA 1993; am § 2 ch 75 SLA 1993; am § 3 ch 76 SLA 1993)

Delayed amendment of paragraph (25). — Under Section 4, ch. 76, SLA 1993, paragraph (23) (now (25)) takes effect on the 180th day after the effective date of Medicaid plan amendments approved by the federal government under which the state would implement a waiver for home and community-based services under 42 U.S.C. 1396n for persons who are Medicaid eligible and who would otherwise require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded in the absence of home and community-based services.

Revisor's notes. — Paragraphs (14) and (15) enacted as (12) and (13) and renumbered in 1992. Renumbered again by the first 1993 amendment. Paragraph (20) was enacted as (19), paragraph (25) was enacted as (23), and paragraph (31) was enacted as (29). Renumbered in 1993.

Effect of amendments. — The first 1991 amendment, effective September 19, 1991, added paragraph (9) (now (11)) and redesignated the succeeding paragraphs accordingly.

The second 1991 amendment, effective September 19, 1991, added paragraphs (1) and (2) (now (2) and (3)) and redesignated the subsequent paragraphs accordingly.

The first 1992 amendment, effective July 1, 1992, added paragraphs (12) and (13) (now (13) and (14)) and redesignated former paragraphs (12) to (24) as paragraphs (14) to (26) (now (15) — (19), (20) — (24), and (26) — (30)).

The second 1992 amendment, effective September 20, 1992, added paragraph (4) (now (5)) and redesignated the subsequent paragraphs accordingly.

The first 1993 amendment, effective July 1, 1993, added present paragraph (1) and redesignated the subsequent paragraphs accordingly.

The second 1993 amendment, effective January 1, 1994, added present paragraph (20) and renumbered the subsequent paragraphs accordingly.

The third 1993 amendment added present paragraph (25), redesignated the subsequent paragraphs accordingly, and added paragraph (31).